UNITED STATES DISTRICT COURT
FOR THE MIDDLE DISTRICT OF PENNSYLVANIA

ANNIE A. KROL-KNIGHT,	:	CIVIL NO. **1:05-CV-0735**
Plaintiff	:	(Magistrate Judge Smyser)
v.	:	
HIGHMARK LIFE & CASUALTY GROUP and HIGHMARK LIFE INSURANCE COMPANY,	:	
Defendants	:	

MEMORANDUM AND ORDER

This civil action was started by a complaint filed on April 12, 2005. The plaintiff, Annie A. Krol-Knight, brought the action to recover long term disability benefits wrongfully denied and to clarify her right to long term disability benefits. The action is brought under the Employee Retirement Income Security Act ("ERISA"), 29 U.S.C. § 1132(a)(1)(B). The plaintiff claims a right to have long term disability benefits under the Highmark Life and Casualty Long Term Disability Plan and an insurance policy that is issued under an "employee benefit plan" pursuant to ERISA, 29 U.S.C. § 1002(3). The court has jurisdiction under 29 U.S.C. § 1132(e)(1). The parties consented to a magistrate judge as the presiding officer pursuant to 28 U.S.C. § 636(c).

The plaintiff resides in Enola, Pennsylvania. The defendant Highmark Life and Casualty Group is a Pennsylvania corporation. The plaintiff worked at Highmark as a claims examiner from July 22, 1991 to April 10, 2003.

A disability insurance policy was provided for employees of Highmark Life and Casualty Group (Highmark Plan). The plan administrator was defendant Highmark Life Insurance Company.

An answer was filed by defendants on June 8, 2005 to the plaintiff's complaint. Doc. 3. A case management conference was held on September 23, 2005, and a case management order was issued. Doc. 13. The parties agreed that the case is appropriate for disposition pursuant to summary judgment motions upon an agreed record. A stipulation filed on January 4, 2006 stated that Doc. 16, Exhibit A is the complete set of administrative records used by the Plan Administrator in determining that the plaintiff was no longer eligible to receive long term disability benefits under the Group Disability Insurance Policy involved here. Summary judgment motions were filed on January 17, 2006 along with briefs and LR 56.1 statements of material fact. Docs. 16-24. Briefs in opposition were filed and answers to LR 56.1 statements were filed.

The plaintiff stopped working on September 5, 2002, and began to receive short-term disability benefits under the Highmark Plan. She had earlier been certified as disabled, in 2001.

The insurer certified disability from March 19, 2001 through April 24, 2001 based upon the report of Dr. Nasir. Doc. 16, p.

14. By notification dated April 30, 2001, Highmark informed the plaintiff that "your claim cannot be certified further since updated medical information received from your attending physician does not support continued disability." *Id.* at p. 15. On May 29, 2001, Highmark notified the plaintiff that, based upon information from Dr. Nasir, disability had been certified from March 19, 2001 through June 12, 2001. *Id.* at p. 16. By letter of June 28, 2001, certification was again extended to July 10, 2001. *Id.* p. 17. By letter of August 6, 2001, the certification was extended to August 19, 2001. *Id.* p. 18.

By letter of October 11, 2001 the plaintiff was told that long term disability payments had been approved. *Id.* pp. 21-22. By letter of November 30, 2001 she was told the following:

November 30, 2001

Ms. Annie Krol-Knight
71 Sherwood Circle
Enola, PA 17025

RE: LONG TERM DISABILITY BENEFITS
CLAIM #2001-262-55447 GROUP POLICY #911760

Dear Ms. Krol-Knight:

We are writing, at this time, to advise you that we have reviewed your claim to determine your eligibility for continued Long Term Disability benefits. According to the policy provisions for Highmark, Inc., you no longer qualify for Long Term Disability benefits. In order to be considered totally disabled from your occupation you must meet the following provisions:

TOTALLY DISABLED

During the first 30 months of one continuous period of disability you must be Totally Disabled from your Own Occupation.

You are Disabled from your own occupation if you are currently unable, as a result of your sickness, accidental bodily injury, or pregnancy, to perform the substantial and material duties of your own occupation, with or without reasonable accommodations by an employer, and you are not working at all.

After careful review of your entire claim file (including your medical records and activities of daily living) our Medical Director has determined that effective November 7, 2001 you no longer meet the definition of disability as described above. Your final check for $255.73, representing benefits from November 1, 2001 through November 7, 2001, has been sent under separate cover.

We will consider any objective medical evidence you wish to submit on your behalf that supports your continued total disability. Objective medical evidence includes, but is not limited to, physician's office notes, test report results, hospital records, therapy notes, consultation and/or narrative reports, etc.

You may request a review of this denial by writing to the Highmark Life Insurance Company representative

> signing this letter. The written request for review must be sent within 60 days of receipt of this letter and state the reasons why you feel your claim should not have been denied. You must include any documentation (medical records/test reports) which you feel supports your claim. Under the normal circumstances, you will be notified in writing of the final decision within 60 days of the date your request for review is received.
>
> Nothing in this letter should be construed as a waiver of any rights or defense under the policy. This determination has been made in good faith and without prejudice under the terms and conditions of the contract, whether or not specifically mentioned herein.
>
> Should you have any information which would prove contrary to our findings, please submit it to us.
>
> Sincerely,
>
> Debra Youngblood
> Disabilities Claim Specialist
> Highmark Life Insurance Company
> 1(800)551-0332 ext. 41171

Id. pp. 23-24.

A second period of disability began September 5, 2002 and extended through February 11, 2003. *Id*. pp. 86-96.

In 2003 and 2004 long term disability payments were made to the plaintiff. The payments were terminated after one year of payments had been made, on March 4, 2004. By letter of March 10, 2004, the plaintiff was informed of this decision. *Id*. pp. 99-102. The determination made was that the plaintiff's "disability is caused by a self-reported condition of pain." Acknowledging that Dr. Nasir had reported that the plaintiff can not work because of back and neck pain, the Disability Specialist who

stated the decision in the letter to the plaintiff explained that Dr. Nasir had based his opinion on the patient's subjective complaint of pain. The Disability Specialist's letter stated:

> Based on a complete review of the medical information reviewed for your LTD claim, we have determined that your disability is caused by subjective complaints of back and neck pain. The testing that Dr. Nasir provided does not show any significant abnormality to explain your continued complaints of pain and your inability to perform your past job as a Claims Examiner.

Id. p. 102. After the plaintiff had submitted additional medical records and had requested a review of the decision, in a letter to the plaintiff dated July 15, 2004 she was told by Highmark that the insurer's position remained the same: "your disability is caused by subjective complaints of back and neck pain." *Id*. p. 115.

The plaintiff and the defendants each present preliminary arguments that will be addressed. The plaintiff argues that the standard of review is a heightened arbitrary and capricious standard. The plaintiff argues that a heightened arbitrary and capricious standard applies because the defendant plan administrator is not a distinct entity from the defendant employer. The defendants argue that defendant Highmark Life & Casualty Group is not a proper party, that a heightened arbitrary and capricious standard should not be applied (or that an only slightly heightened standard should apply), that the decision to deny long term disability benefits was not arbitrary and capricious, and that the decision is supported by substantial

evidence.

The record available to the court conducting an arbitrary and capricious review is the record made before the plan administrator, which can not be supplemented during litigation. *Kosiba v. Merck & Co.*, 384 F.3d. 58, 67 n.5 (3d Cir. 2004). When a reviewing court is deciding whether to apply the arbitrary and capricious standard or a more heightened standard of review, however, it may consider evidence of potential bias and conflicts of interest that are not found in the administrator's record. *Id. Bowman v. Hartford Life and Accident Insurance Company*, 2005 WL 2370852 (M.D.Pa. Sept. 27, 2005).

The plaintiff's argument that a material conflict of interest is present here is that "the policy at issue contains a provision that expressly grants Highmark discretionary authority to interpret the plan and to determine eligibility for benefits" and that Highmark is both the administrator or fiduciary and insurer of the policy.

The defendants' argument is for the application of a heightened standard of review "under a sliding scale" acknowledging that Highmark Life both determines eligibility for benefits and pays those benefits. The defendants argue that a standard of review at "the mild end of the heightened arbitrary and capricious scale" should be applied because there is no

evidence of a conflict other than the inherent structural conflict in having one entity both determine eligibility and pay benefits. The defendants rely upon *Bowman*, supra. The plaintiff does not point to any basis for a determination that an application of any of the factors reviewed in *Bowman* - (1) the sophistication of the parties, (2) the information accessible to the parties, (3) the exact financial arrangement between the parties, and (4) the status of the fiduciary - would warrant greater that a slightly heightened arbitrary and capricious standard of review here. We will apply a slightly heightened standard of review here.[1]

Summary judgment is appropriate if the "pleadings, depositions, answers to interrogatories, and admissions on file, together with the affidavits, if any, show that there is no genuine issue as to any material fact and that the moving party is entitled to judgment as a matter of law." Fed.R.Civ.P. 56(c)). "The moving party bears the initial burden of demonstrating the absence of any genuine issue of material fact, though the non-moving party must make a showing sufficient to establish the existence of each element of his case on which he will bear the burden of proof at trial." *Huang v. BP Amoco Corp.*,

[1]As our analysis below progresses, we will find the issue to become reduced to an interpretation of the SELF REPORTED SYMPTOMS provision of the policy. Our determination below that the provision was not incorrectly interpreted or applied would be unaffected by an application of a very heightened standard of review, rather that a more deferential or mild standard.

271 F.3d 560, 564 (3d Cir. 2001); *Celotex Corp. v. Catrett*, 477 U.S. 317, 322-23 (1986). "A factual dispute is material if it bears on an essential element of the plaintiff's claim, and is genuine if a reasonable jury could find in favor of the nonmoving party." *Natale v. Camden County Correctional Facility*, 318 F.3d 575, 580 (3d Cir. 2003).

The application of the substantial evidence standard of review is not a fact finding process. Despite the necessity of using Rule 56 of the Federal Rules of Civil Procedure as the procedural device and as the legal authorization for a case dispositive motion to the court to review the administrative record and to decide whether the insurer's decision may or may not stand, and despite the presence of a putative reasonable fact finder in summary judgment analysis as a general matter, there is no use to be made of the reasonable fact finder in this particular context. There is no role to be played by a fact finder in the court's determination of the case when deciding whether the plan administrator's decision was arbitrary and capricious.

The issue presented, accordingly, is whether the plan administrator's decision is arbitrary and capricious because the plan has been misinterpreted or because there is not substantial evidence in the record to support the decision. *Adamo v. Anchor Hocking Corp.*, 720 F.Supp. 491, 500 (W.D.Pa. 1989).

The plaintiff's disability insurance policy contains a provision (SELF REPORTED SYMPTOMS) that provides that long term disability benefit payments for any disability caused or contributed to by self-reported symptoms, unless symptoms can be verified by generally accepted medical tests, procedures or examinations, are limited to 12 months of payments. Doc. 22, p.20. The definition of self-reported symptoms includes, as an example, pain.

Upon consideration of the Plan, the plaintiff's long term disability claim, and the plan administrator's rationale for the decision, we conclude as a matter of law that the decision is not arbitrary and capricious, for the reason that the plaintiff had collected benefits for 12 months and had presented a disability claim based in part upon pain, a self-reported symptom, when the pain symptoms can not be verified using generally accepted test, procedures or clinical examinations.

Under the arbitrary and capricious standard of review the court must defer to the decision of the plan administrator unless the decision is not supported by the evidence in the record or the administrator has not applied the provision of the plan. *Abnathya v. Hoffman-LaRoche, Inc.*, 2 F.3d 40,45 (3d Cir. 1993). The court is not authorized to substitute its judgment in considering the evidence for that of the plan administrator.

A digest of the plaintiff's medical conditions and symptoms was prepared by Dr. Philip Jordan Marion, M.D., Doc. 16, pp. 271-277, and was submitted on November 13, 2003 to Highmark. The plaintiff's criticism of Dr. Marion's determination that the plaintiff "is functionally capable of performing regular duty without any restrictions" is that Dr. Marion did not himself make a determination of the plaintiff's disability but rather based his determination upon a review of the medical records. The plaintiff does not, in criticizing the plan administrator's reliance upon Dr. Marion's report nor elsewhere in her arguments, address the significance and the application of the contractual SELF REPORTED SYMPTOMS provision.

The SELF REPORTED SYMPTOMS provision provides in part that a disability contributed to by pain is limited to 12 months of payments. The plaintiff was paid benefits for 12 months and is precluded by the contract from further benefits if her pain is a self-reported symptom within the meaning of this provision. The provision also states that a self-reported symptom is a symptom that the patient (insured) has reported to her physician that can not be verified using tests, procedures or clinical examinations that are generally accepted in the practice of medicine.

An independent medical examination on February 11, 2003, Doc. 16 pp. 235-244, is of no probative value to the plaintiff; there is no objective verification of pain. The plaintiff's

physicians, Dr. Hanks and Dr. Nasir, diagnosed, or verified, her pain symptoms as to her back and neck pain, by no objective test results. Dr. Hanks accepted the veracity of the reported pain. Dr. Lippe determined her hand pain to be associated with carpal tunnel syndrome and apparently remedied it by a carpal release procedure. Her doctors interpreted the objective findings from radiographic diagnostic studies to indicate disc bulging and encroachment and apparently inferred some veracity in her reports of pain from that. See, Doc. 16, p. 273. Dr. Marion characterized her back impairment as being in the mild category. Dr. Marion also noted an absence of objective neurological deficits. *Id*. p. 274. The record does not contain evidence purporting to be or reasonably construed to be verification of pain symptoms through test, procedures or examinations. Medical evidence in the record that could be construed to support a finding that the plaintiff has a medical condition that could reasonably be seen to give rise to or to cause her pain symptoms does not equate to verification of pain symptoms. The administrator's interpretation considers pain to be a self-reported symptom that can not be verified or at least that has not been verified here.

The interpretation and application of the SELF REPORTED SYMPTOMS contract provision is not discussed by the plan administrator here beyond a statement that it defeats the claim. The plan administrator clearly felt it to be adequate to start

and to stop the analysis with the finding that the disability is caused by a self-reported condition of pain. The plan administrator has construed the policy to preclude long term disability payments when the disability is based in part upon the subjective symptoms attendant to an impairment, no matter how objectively established the impairment is and no matter how generally accepted the relationship is between the impairment and the symptoms, unless the subjective symptoms are verified.

The plan administrator has not construed the policy in a manner that is not based upon a correct construction of the SELF REPORTED SYMPTOMS section of the policy. The provision plainly limits the payment of long term disability benefits to a total of 12 months when the disability is caused by or contributed to by the person's unverified pain.

No basis is presented by the plaintiff for a finding that the policy so construed does not provide a justification for the decision here. We conclude that there was substantial evidence to support a finding that the plaintiff's disability is contributed to by her self-reported symptoms, and that the decision was not arbitrary or capricious.

The employer defendant, Highmark Life and Casualty Group, argues that it is not a proper party to this action and that the action should be dismissed as to Highmark Life and Casualty

Group. We will not reach or address that argument, in that summary judgment will be granted in favor of both defendants and against the plaintiff.

The defendants' motion for summary judgment will be granted and the plaintiff's motion for summary judgment will be denied.

IT IS ORDERED that the defendants' motion for summary judgment is GRANTED and that the plaintiff's motion for summary judgment is DENIED.

/s/ J. Andrew Smyser
J. Andrew Smyser
Magistrate Judge

Dated: March 9, 2006.